Filed 4/26/12 Eull v. Providence Little Co. of Mary CA2/3

NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

CLINTON B. EULL, III et al., Plaintiffs and Appellants, v. PROVIDENCE LITTLE COMPANY OF MARY, Defendant and Respondent,	B227903 (Los Angeles County Super. Ct. No. YC060865)

APPEAL from a judgment of the Superior Court of Los Angeles County, Andrew C. Kaufman, Judge. Affirmed.

Kantor & Kantor, J. David Oswalt and Christina J. Smith for Plaintiffs and Appellants.

Huskinson, Brown, Heidenreich & Carlin, Brian C. Carlin and Paul Heidenreich for Defendant and Respondent.

This is an appeal from a judgment entered in favor of respondent Providence Little Company of Mary (Hospital) after the trial court sustained Hospital's demurrer without leave to amend. The trial court did so on the ground that appellants had failed to allege any factual basis for recoverable damages. Indeed, a review of their claims demonstrates that, as a matter of law, they have sustained no damages. The trial court's ruling was correct and we will affirm the judgment.

FACTUAL AND PROCEDURAL BACKGROUND[1]

Clinton B. Eull, III (Mr. Eull) is married to Marielinne L. Lie Eull[2] (Mrs. Eull) (together, the Eulls or appellants). Mr. Eull was and still is a subscriber under a Blue Shield PPO health plan (Blue Shield Policy). A PPO Plan is one "under which the highest benefits are provided when the Subscriber uses a 'Preferred Provider,' i.e., a physician or hospital that had contracted with Blue Shield and had agreed to accept the [sic] Blue Shield's payment, plus the Subscriber's copayment, as payment-in-full for covered services."[3] Under this Policy, Mr. Eull is responsible "for the annual deductible

---

[1] The factual background discussion is based primarily on the allegations in appellants' second amended complaint, which is the operative complaint in this appeal. The procedural history of this case is reflected in appellants' two-volume appendix.

[2] Although the trial court questioned Mrs. Eull's standing on the basis that she had not been damaged by Hospital's breach of its contract with Blue Cross, it ultimately sustained the demurrer without leave to amend because it concluded that neither Mr. nor Mrs. Eull had alleged any basis for the recovery of damages. Therefore, we have no need to address the issue of standing with respect to Mrs. Eull.

[3] "In a PPO plan, there is a designated panel of preferred providers with whom a third[-]party payor has contracted to provide medical services to insureds at discounted rates. The providers agree to discount their rates in part because they are guaranteed a defined pool of patients who have an economic incentive to use a preferred

and a copayment of 30 percent of the allowed amount for most services." Mr. Eull pays the premiums and Mrs. Eull "was not and is not an insured under the Blue Shield Policy."

Mrs. Eull was and still is a subscriber under a Blue Cross HMO health plan (Blue Cross Policy). Under an HMO plan, " 'Participating Medical Groups' are paid a capitation fee, a set and agreed to dollar amount per Subscriber each month, for medical services . . . [and] participating hospitals and other health care facilities are paid negotiated fixed fees or negotiated discounts from their standard fee-for-service rates. [These providers] agree to accept the Blue Cross payments as payment-in-full . . . [¶] for Blue Cross HMO subscribers such as [Mrs. Eull]."

In September of 2005, Mrs. Eull, who was pregnant at the time, was admitted to Hospital because of preterm labor. On November 10, 2005, she gave birth to triplets who required substantial medical care. After their birth, the triplets were enrolled as dependents under both of the health plans at issue. After Mrs. Eull and the triplets were discharged in early 2006, Hospital billed both Blue Cross and Blue Shield for the services provided. Hospital is both a preferred provider as to Blue Shield and a participating hospital as to Blue Cross. Both Blue Cross and Blue Shield paid their full contract rate. Blue Shield's payment was approximately $600,000. The record does not disclose the amount (or value) billed to or paid by Blue Cross; nor does the

---

provider. Although the insureds typically are not precluded from using providers who are not preferred providers, they have to pay significantly more for services from nonpreferred providers." (*Lori Rubinstein Physical Therapy, Inc. v. PTPN, Inc*. (2007) 148 Cal.App.4th 1130, 1136.)

Eull's complaint allege any facts or information by which it could be determined that Hospital had been "overpaid" the amount due for the medical care and services that it provided. It appears, however, that there is no claim by any party to this action that Hospital's bill was not paid in full.

After learning in 2007 that Blue Shield had paid $600,000 to Hospital under the terms of *its* policy, the Eulls filed a complaint followed by a first amended complaint, for which a demurrer with leave to amend was sustained. On April 26, 2010, the Eulls filed a second amended complaint (SAC), the operative complaint in this appeal, which included four causes of action against Hospital: (1) breach of contract based on the Eulls' status as third-party beneficiaries of a contract between Blue Cross and Hospital; (2) breach of the financial responsibility contract between Mrs. Eull and Hospital; (3) restitution due to unjust enrichment; and (4) declaratory relief with respect to the contract between Blue Cross and Hospital. In support of these claims, the SAC makes a number of factual allegations which are discussed in more detail below.

Hospital demurred to the SAC and the trial court sustained the demurrer without leave to amend. Judgment was entered in favor of Hospital shortly thereafter. Appellants then filed this timely appeal.

ISSUES ON APPEAL

Appellants contend that the trial court's sustaining of Hospital's demurrer without leave to amend was in error because the allegations of the SAC were sufficient to state viable causes of action. Thus, they argue, the judgment of dismissal should be reversed and the matter remanded to the trial court for further proceedings. Appellants

raise several arguments in support of this contention, but the resolution of the issue of damages is dispositive. Our review of this record demonstrates that appellants, even if they were third-party beneficiaries of the contract between the Hospital and Blue Cross, have sustained no damages as a result of the circumstances alleged in their second amended complaint.

DISCUSSION

1. *Standard of Review*

We review an appeal from a judgment of dismissal after a demurrer is sustained without leave to amend under the de novo standard. (*Neilson v. City of California City* (2005) 133 Cal.App.4th 1296, 1304-1305.)

When reviewing a demurrer that is sustained without leave to amend, we assume the truth of (1) appellant's properly pled facts in the operative pleading, including those facts contained in the exhibits attached thereto; (2) all facts that are properly the subject of judicial notice; and (3) all facts that may reasonably be inferred from the foregoing. (*Neilson v. City of California City*, *supra*, 133 Cal.App.4th at p. 1305.) This rule, however, extends only to properly pleaded material facts; it does not apply to "contentions, deductions or conclusions of fact or law." (*Blank v. Kirwan* (1985) 39 Cal.3d 311, 318.)

Code of Civil Procedure section 430.10 states in relevant part, "The party against whom a complaint or cross-complaint has been filed may object, by demurrer . . . to the pleading on any one or more of the following grounds: . . . [¶] (e) The pleading does not state facts sufficient to constitute a cause of action." A demurrer on this ground will

be upheld "only if the complaint fails to state a cause of action under any possible legal theory." (*Sheehan v. San Francisco 49ers, Ltd*. (2009) 45 Cal.4th 992, 998.)

With this standard of review in mind, we now turn to the allegations of the operative pleading.

2. *Appellants Have Not Pled Facts Sufficient To Demonstrate That They Have Suffered Recoverable Damages*

Appellants' claim against Hospital, as alleged in their first cause of action, rests upon the contention that Hospital breached its contract with Blue Cross when it billed Blue Shield for the services provided to the triplets. They contend further that they have a right to enforce that contract as third-party beneficiaries.[4]

Appellants, in the SAC, allege that Hospital "has entered into an agreement with Blue Cross whereby it has agreed to accept payments of negotiated fixed fees or negotiated discounts made under the Blue Cross HMO Policy as payment-in-full for Blue Cross HMO subscribers . . . . " They allege that the contract "prohibits [Hospital] from seeking to recover amounts in excess of the negotiated fixed fees or negotiated discounts from subscribers or the subscriber's other insurance." Although a copy of the alleged contract was not attached to the SAC, pleading the legal effect of a contract, by alleging the making and the substance of its relevant terms, is sufficient. (See *Construction Protective Services, Inc. v. TIG Specialty Ins. Co*. (2002) 29 Cal.4th 189, 198-199.) Furthermore, if a contract's terms are ambiguous, the appellant's

---

[4] For purposes of the resolution of this appeal, we assume, arguendo, that the Eulls had standing as third-party beneficiaries to sue for the claimed breach of the Blue Cross/Hospital contract.

interpretation must be accepted if the contract's terms are reasonably susceptible to such interpretation. (*Aragon-Haas v. Family Security Ins. Services, Inc*. (1991) 231 Cal.App.3d 232, 239.)

The SAC does allege the non-breaching party's performance under the contract. It alleges that the premiums for coverage under the Blue Cross policy were paid, Hospital provided medical care to the triplets and Blue Cross paid its "full contract rate for [Hospital's] billings." The SAC, however, nowhere alleges the amount or value of Hospital's total billing for all services or how much was billed to Hospital by Blue Cross or whether Hospital was in anyway "overpaid" the reasonable value of the services it provided.

The SAC also alleges that Hospital billed "both Blue Cross and Blue Shield and that both Blue Cross and Blue Shield had each paid their full contract rate." It further alleges that Hospital admitted to such billing in a letter sent to Mr. Eull, which states, "In the case of your triplets, your Blue Cross HMO Policy required [Hospital] to bill Blue Shield of California as Prime and receive payment from Blue Shield of California prior to submitting a bill to Blue Cross of California. Blue Shield of California paid [Hospital] per their contract rate . . . [and] Blue Cross of California coverage was then billed, as is standard in the case of multiple health insurance coverage . . . . " The SAC further alleges that the Blue Cross HMO Policy does not require Hospital to bill Blue Shield first and that such practice was not permitted by the alleged contract between Hospital and Blue Cross resulting in Hospital's breach. The Blue Cross document

attached as Exhibit B to the SAC does not include language that specifies that it pays secondary to other insurance coverage for its subscribers.

In order to plead a viable claim for breach of contract, however, appellants were also required to allege that they had suffered recoverable damages. As we will explain, they did not do so. The allegations of the SAC include four specific damage claims: (1) a refund to them of the $600,000 "overpayment" paid by Blue Shield to Hospital; (2) the restoration of the $600,000 reduction in their $6,000,000 lifetime limit on benefits under the Blue Shield Policy; (3) recovery of the amount of their annual deductible to Hospital per the Blue Shield Policy; and (4) recovery of the 30 percent copayment to Hospital pursuant to the Blue Shield Policy.[5] Each of these damage claims is without legal merit in that none of these claimed damages are recoverable by appellants' in this case. As a result, each of appellant's alleged causes of action must fail.

a. *Appellants Are Not Entitled to a "Refund" of the $600,000 Payment Made To Hospital by Blue Shield*

Appellants claim that the $600,000 paid by Blue Shield should be refunded to them because it exceeded the negotiated amounts that Hospital was entitled to collect under the Blue Cross/Hospital contract. Counsel for appellants stated on the record that it was appellants' position that had Hospital not billed Blue Shield, they would be

---

[5] Appellants' counsel stated on the record before the trial court that he did not believe that Hospital had ever billed appellants for the 30 percent copayment and that he did not know whether appellants had paid the deductible or the copayment. Counsel also stated that he did not think that appellants had made such payments. In addition, Hospital's counsel stated on the record that Hospital had no intention of billing appellants for any costs associated with the triplets' hospitalization.

entitled to the $600,000 due under the terms of the Blue Shield Policy. In other words, they claim that *they* were entitled to receive payment directly from Blue Shield for any amount due to a medical provider. As authority for their argument, appellants rely heavily on a case from the Arizona Court of Appeals, *Nahom v. Blue Cross and Blue Shield of Arizona, Inc*. (1994) 180 Ariz. 548 (*Nahom*). No California court has adopted *Nahom's* analysis and, despite appellants' urging, we decline to apply it in this case for the reasons we discuss below.

In *Nahom*, the plaintiff claimed he was a third-party beneficiary of a participation agreement between Scottsdale Memorial Hospital (Scottsdale Memorial) and Blue Cross and Blue Shield of Arizona, Inc. (Blue Cross). (*Nahom, supra*, 180 Ariz. at p. 550.) Under the participation agreement, Scottsdale Memorial was obligated to accept Blue Cross's payment for services relating to his wife's hospitalization as payment-in-full. (*Id*., at p. 551.) The plaintiff's wife was covered not only by Blue Cross but also by an Oakmark group policy that had been issued through her employer.

Scottsdale Memorial's billed charges for her stay were $112,672.36 and it submitted claims to both insurers. (*Nahom, supra*, 180 Ariz. at p. 551.) Oakmark paid $110,989.69. (*Ibid*.) Blue Cross paid $22,857.10, based on her diagnosis and its prearranged DRG or FARE[6] amounts per the participation agreement. (*Ibid*.)

---

[6] " 'DRG' stands for 'Diagnostic Related Groupings.' " (*Nahom, supra*, 180 Ariz. at p. 551, fn. 2.) " 'FARE' stands for 'Fair Allowance Reimbursement Effort.' " (*Id*., at p. 551, fn. 1.) "The DRG or FARE amounts are determined in the participation agreement between Blue Cross and Scottsdale Memorial. These fixed amounts put a cap on Blue Cross amounts paid to hospital providers for certain illnesses." (*Id*., at p. 551.)

Scottsdale Memorial refunded $21,174.43 to the plaintiff which was the excess it received over the billed charges. (*Ibid*.) The plaintiff sued the hospital asserting that "Scottsdale Memorial [was] required by the participation agreement to accept the FARE or DRG amount as payment in full for the hospitalization of a Blue Cross subscriber [i.e., his wife]. He further claim[ed] that as a third-party beneficiary of the participation agreement, he [was] entitled to all available insurance benefits in excess of the DRG amount." (*Ibid*.) The trial court agreed and entered judgment in his favor. On appeal, the *Nahom* court affirmed the lower court stating that because there was no effective coordination of benefits clause,[7] both policies were required to pay primary and "the insured who paid for hospitalization coverage is entitled to full benefits under both policies even if this payment exceeds the hospital bills." (*Id*., at p. 554.)

---

[7] Appellants raised in their reply brief that "neither [Mrs. Eull's] Blue Cross Policy nor [Mr. Eull's] Blue Shield Policy contain[s] coordination of benefits clauses.[] They do not because they are individual, not group policies, and, under California law, individual policies are not permitted to coordinate benefits." (See Ins. Code, § 10270.98.) Appellants' counsel appeared to argue before this court that Hospital engaged in improper coordination of benefits by seeking payment from Blue Shield instead of accepting the amount paid by Blue Cross as payment-in-full for Hospital's treatment of the triplets. Although this contention was advanced with respect to the original complaint and also the first amended complaint, it was not asserted in the SAC. Even if it were, it would be entirely without merit as the purpose of a coordination of benefits clause is to allow insurers to reduce, exclude or adjust benefits and appellants admit that Blue Shield and Blue Cross each paid their full contract rate. (See *Whiteside v. Tenet Healthcare Corp*. (2002) 101 Cal.App.4th 693, 701-702 (*Whiteside*).) In other words, no coordination of benefits occurred as there was no reduction in benefits under either policy. Additionally, when appellants filed a grievance with Blue Shield complaining that it "overpaid" Hospital, Blue Shield confirmed that no coordination occurred by stating, "During a review of the provisions and benefits of your Individual and Family Health Plan, there are no provisions to coordinate benefits with another health plan. Our system shows that your primary insurance is Blue Shield as we do not coordinate with other plans."

In coming to this conclusion, the *Nahom* court relied on the specific contract language which stated that Scottsdale Memorial "agreed to accept the FARE/DRG amount 'as payment *in full* for covered services performed for subscriber.' " (*Nahom*, *supra*, 180 Ariz. at p. 553.) The *Nahom* court also supported the conclusion it reached by extending, by analogy, cases involving Medicare/Medicaid payments, which it stated, "recognize[d] the patient's right to receive a cash payment from private insurance policies lacking an effective coordination of benefits clause where the hospital bills have been previously paid." (*Nahom, supra*, 180 Ariz. at p. 555.) Without citing any specific authority, the *Nahom* court went on to state, "The majority rule holds that an insured is entitled to double benefits if two policies lack effective coordination of benefits clauses. On these facts, Scottsdale Memorial had no authority to charge Blue Cross subscribers amounts above the DRG or to impose additional charges against other insurance." (*Ibid*.)

The decision in *Nahom* is inconsistent with California law. (See *Whiteside, supra*, 101 Cal.App.4th at p. 704.) Moreover, the conclusion reached by the *Nahom* court does not necessarily follow in a situation in which an insured is covered under policies that specify that benefits are to be paid direct to the health care provider and do not provide for cash payments to the insured. To reach the *Nahom* conclusion under such circumstances, it is necessary to assume that a benefit in the form of direct payments to a provider *is the same as* an entitlement to receive the monetary equivalent of that same benefit. Whereas this may be a correct legal assumption in Arizona, it is not the case here in California. (*Whiteside, supra*, 101 Cal.App.4th at p. 703 [stating,

where insured was eligible to receive benefits from insurance company in the form of direct payment to the hospital, "insurance proceeds were not an asset legally equivalent to money in a bank account or a life insurance policy owned by [insured]".]) Exhibit A to the SAC contains the express statement, "Preferred Providers are paid directly by Blue Shield of California. The Person[8] or the provider of Service may not request that payment be made directly to any other party." Therefore, *Nahom* is of no help to appellants.

Appellants also rely on *Parnell v. Adventist Health System/West* (2005) 35 Cal.4th 595 (*Parnell*) to support their argument that Hospital was contractually bound to not seek payments from Blue Shield because doing so was the equivalent of seeking payments directly from appellants. Thus, appellants argue, they are entitled to a refund of the $600,000 paid. We disagree.

In *Parnell*, our Supreme Court analyzed whether a hospital could assert a lien against a patient's damages recovered in a suit against the tortfeasor who injured the patient. "Under the Hospital Lien Act (HLA; Civ. Code, §§ 3045.1-3045.6), a hospital that treats a patient injured by a third[-]party tortfeasor may assert a lien against any judgment, settlement, or compromise recovered by that patient from the tortfeasor in the amount of its 'reasonable and necessary charges' (§ 3045.1). In this case, a hospital received payment from a patient and his health insurer and agreed to accept that payment as 'payment in full' for its services. Nonetheless, the hospital asserted a lien

---

[8] The Blue Shield Policy defines "Person" as "either the Subscriber or Dependent."

under the HLA, seeking to recover the difference between its usual and customary charges and the amount received from the patient and his insurer." (*Id*., at p. 598.) The *Parnell* court concluded that, under the terms of the agreement, the patient's bill was paid in full and he no longer owed a debt to the hospital for its services. (*Id*., at p. 609.) Therefore, it reasoned, the hospital's assertion of a lien under the HLA against the patient's *recovery from the tortfeasor* was improper because it was essentially the same as seeking additional payments from the patient. (*Ibid*.)

Parnell is distinguishable in that the patient in that case *was* otherwise entitled to receive the payment of the judgment or settlement proceeds *directly* from the tortfeasor. Here, appellants were not entitled to directly receive any payment under the terms of their Blue Shield Policy. Seeking direct payment from an insurance company on behalf of an insured is not "equivalent to obligating him to pay for services." (*Whiteside*, *supra*, 101 Cal.App.4th at p. 704.) Thus, *Parnell* does not apply here and appellants have cited no additional authority to support their contentions.

Like the plaintiff in *Whiteside*, appellants' mistaken belief that by having coverage under an HMO plan and a PPO plan they can "pocket" the money paid under the PPO plan every time they have a claim that is covered under both plans "is simply not a reasonable expectation." (*Whiteside*, *supra*, 101 Cal.App.4th at p. 705.) Appellants "either ignore[] or misapprehend[] the provisions of [their] insurance policies regarding the payment of claims. The basic obligation of the medical insurers is to pay the medical providers directly for their services and to insulate the insured[s] from any monetary obligation for such medical care. [Appellants are] entitled to no

more than that under the terms of [their] coverage." (*Ibid*.) If, in fact, Blue Shield overpaid Hospital, it is Blue Shield that is entitled to a refund, not appellants.[9]

Additionally, appellants' claim for $600,000 in damages is barred by the doctrine of collateral estoppel because of the prior final judgment entered in favor of Blue Shield. In the SAC, appellants alleged that Blue Shield had breached its policy with them by paying $600,000 to Hospital. Appellants alleged that the policy provided that " 'no benefits are provided for Services . . . [f]or which the Person is not legally obligated to pay.' The policy defines 'Person' as either the Subscriber or a Dependent." They further alleged that "neither [Mr. Eull] nor the triplets as Dependents under the Blue Shield Policy were legally obligated to pay any amounts billed by [Hospital] in excess of the contract rate paid to [Hospital] by Blue Cross. Accordingly, Blue Shield breached the Blue Shield Policy when it paid [Hospital's] bills for services provided to the triplets in connection with their birth." They also alleged that they were "entitled to a refund of all amounts paid to [Hospital] by Blue Shield."

Blue Shield filed a demurrer and argued that the terms of the Blue Shield Policy only required that Blue Shield pay a preferred provider on behalf of its subscriber and did not provide for payments directly to such subscriber. Further, Blue Shield argued that appellants' position regarding the $600,000 relied on the assumption that, absent Hospital's billing of Blue Shield, they were entitled to receive the funds under the Blue

---

[9] As we have already noted, appellants' SAC is simply devoid of any factual allegation that would support the conclusion that there was an "overpayment" to Hospital. The appellants' conclusionary assertion is just that, an unsupported conclusion that we are not required to accept as true. (*Blank v. Kirwan, supra,* 39 Cal.3d at p. 318.)

Shield Policy directly. The trial court agreed with Blue Shield's counsel that the Blue Shield Policy was not a traditional indemnity policy and only required Blue Shield to pay preferred providers directly. It sustained Blue Shield's demurrer without leave to amend and entered a judgment in its favor. That judgment was not appealed and is now final.

The necessary elements of the doctrine of collateral estoppel are: (1) the same issue was actually and necessarily decided; (2) there is a final judgment on the merits; and (3) the party to be estopped was a party or in privity with a party to the prior action. (*Lucido v. Superior Court* (1990) 51 Cal.3d 335, 341.) The prior judgment in favor of Blue Shield satisfies all three of these requirements. The same issue involved in appellants' claim against Blue Shield is now being asserted against Hospital; that is, that appellants are entitled to receive from Hospital the $600,000 that was paid to it by Blue Shield. A final judgment of dismissal with prejudice was entered in favor of Blue Shield on this issue; and appellants were clearly parties to the claim against Blue Shield. As a result, appellants are collaterally estopped from relitigating the issue of whether they are entitled to receive any of the $600,000 paid under the Blue Shield Policy. (See, *Huber v. Jackson* (2009) 175 Cal.App.4th 663, 677 ["Collateral estoppel, one of two aspects of the res judicata doctrine, precludes the relitigation of an identical issue necessarily decided in previous litigation."].) If appellants were not entitled to receive that sum from Blue Shield, then they have no basis for demanding such payment from Hospital.

Based on the foregoing, appellants are not entitled to receive any of the $600,000 that Blue Shield paid to Hospital, as a refund or otherwise. As a matter of law, they cannot claim such amount as damages in their suit against Hospital.

b. *Any Claim For Damages Based on the Reduction of Appellants' Lifetime Limit on Benefits is Barred by the Doctrine of Collateral Estoppel*

Appellants' contention that they have been damaged by Hospital's breach of the Blue Cross/Hospital contract based on a $600,000 reduction in their $6,000,000 lifetime limit on benefits under the Blue Shield Policy is also without merit.[10] It was not Hospital that lowered appellants' lifetime limit on benefits under the Blue Shield Policy, but rather Blue Shield. Appellants admit this in the SAC, stating, "Blue Shield's payments to [Hospital] significantly reduced the insurance available under the Blue Shield Policy because they lowered the dollar amount of the aggregate benefits available under the policy." Appellants did, in fact, include this same claim for damages in the SAC with respect to the causes of action brought against Blue Shield. Thus, the collateral estoppel analysis discussed above applies to this claim as well. As a result, appellants are collaterally estopped from relitigating this issue. (*Huber v. Jackson*, *supra*, 175 Cal.App.4th at p. 677.)

Moreover, it appears from this record that appellants in fact received the benefit of $600,000 in medical care and services. The reduction in lifetime benefit is expressly

---

[10] It is possible that the decrease in appellants' lifetime limit on benefits is too remote and speculative to recover because they have not alleged that they have actually reached such limit and are being denied benefits as a result. Also it is not certain that appellants will ever reach such limit given that they could cancel their insurance policy prior to doing so.

contemplated by the Blue Shield policy and is something to which appellants had agreed. Appellants have alleged no facts showing that any action of Hospital *wrongfully* deprived them of that benefit or that such payment was not required to fully discharge the billing for services rendered. If Hospital improperly billed Blue Shield and received $600,000 on account of the hospital services rendered to appellants, that is an issue between Blue Shield and Hospital. Appellants have received all of the benefits to which they were entitled when Hospital's bill was paid in full.

c. *Appellants' Claim That They Have Incurred Deductible and Co-Payment Liability to Hospital Are Without Merit*

Appellants argue that, as a result of Hospital's billing to Blue Shield, they are exposed to liability to Hospital for the amount of the annual deductible and the 30% co-payment specified in the Blue Shield policy. These claims are plainly a fiction. There are no allegations that appellants were ever required to pay such amounts to Hospital or that they did pay such sums or that they were even billed for them.

Moreover, the obligation to make such payments arose, if at all, in early 2006, over six years ago. The relevant statute of limitations has long since run. Hospital, which seemingly has acknowledged that its bill had been *fully* paid by Blue Cross and Blue Shield,[11] could not now assert any viable claim for these sums against appellants. Thus, as a matter of law, neither of these claims can be the basis for any damages recoverable against Hospital.

---

[11] See footnote 5, *ante*.

3. *Appellants' Claims Based on Theories Other Than Breach of the Hospital/Blue Cross Contract Are Likewise Without Merit*

a. *No Cause of Action for Breach of the "Financial Responsibility" Agreement Has Been Stated*

Appellants contend that Hospital breached its "financial responsibility" agreement signed by Mrs. Eull when it billed Blue Shield.[12] Specifically, appellants argue that when Hospital accepted Blue Cross's payment on Mrs. Eull's behalf, such payments constituted payment-in-full and appellants no longer owed a debt to Hospital for those services. Thus, appellants argue, Hospital's billing to Blue Shield for additional compensation was a breach of the financial responsibility agreement.

The portion of the financial responsibility agreement at issue states, as quoted in the SAC, "The undersigned authorizes . . . direct payment to the hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services . . . at a rate not to exceed the hospital's actual charges. It is agreed that payment to the hospital, pursuant to this authorization, by the insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment." Nothing in this language suggests that Hospital was not permitted to seek

---

[12] Appellants also briefly mention that Mr. Eull did not sign such an agreement regarding payments from Blue Shield and thus, the benefits under the Blue Shield Policy had not been assigned to Hospital. However, the "Insurance Code certainly permits insurers to contract to make payments due under . . . insurance policies directly to the provider of hospital and medical services." (*Whiteside, supra*, 101 Cal.App.4th at p. 701, fn. 3; see also Ins. Code, §§ 10133, 10133.7 and 10350.9.) As a result, such an assignment of benefits agreement with Hospital was not necessary.

additional reimbursement from an insurance company other than Blue Cross. Without such limiting language, there can be no breach of the contract as appellants claim. Thus, appellants have failed to adequately plead a breach of the financial responsibility agreement.

b. *The Cause of Action for Restitution Based on Unjust Enrichment Is Insufficient*

Appellants contend that Hospital was unjustly enriched at their expense when it retained the $600,000 paid by Blue Shield. Appellants argue that they are entitled to a refund of such proceeds because these amounts exceeded the amount paid by Blue Cross, which Hospital allegedly agreed to accept as payment-in-full for the services provided to the triplets. This cause of action was pled in the alternative to appellants' third-party breach of contract and breach of financial responsibility contract claims.

As we explained above, even if the $600,000 at issue was not properly paid to Hospital by Blue Shield, appellants are not entitled to a refund. Thus, this cause of action fails because appellants have not properly pled facts showing *their* entitlement to such restitution.

c. *The Cause of Action for Declaratory Relief is Insufficient*

Appellants contend that an actual controversy has arisen with Hospital concerning the parties' respective rights and duties under the agreement between Blue Cross and Hospital. Appellants seek a judicial determination of such rights and duties with respect to the payments made by Blue Cross and Blue Shield for services provided by Hospital to the triplets.

Declaratory relief may be sought where an "actual controversy relating to the legal rights and duties of the respective parties" exists. (Code Civ. Proc., § 1060.) "There is unanimity of authority to the effect that the declaratory procedure operates prospectively, and not merely for the redress of past wrongs. It serves to set controversies at rest before they lead to repudiation of obligations, invasion of rights or commission of wrongs; in short, the remedy is to be used in the interests of preventive justice, to declare rights rather than execute them. [Citations.]" (*Travers v. Louden* (1967) 254 Cal.App.2d 926, 931.) Here, appellants seek to redress the past wrong of Hospital's alleged breach of its agreement with Blue Cross, a wrong for which declaratory relief is generally not available.

Appellants argue in their opening brief that *Warren v. Kaiser Foundation Health Plan, Inc.* (1975) 47 Cal.App.3d 678 (*Warren*) provides an exception to the aforesaid general rule where there is a continuing relationship between the parties governed by the terms of the contract they seek to clarify. In *Warren*, however, the plaintiff brought suit for declaratory relief *instead* of a breach of contract action and the court stated, "In summary, appellant pleaded a controversy concerning the construction of the contract

creating the Kaiser plan and facts establishing the proposition that declaratory relief is faster, more adequate, and better suited than would be an action for breach of contract. Under those circumstances, the trial court was in error in exercising its discretion to deny the remedy." (*Id*., at p. 684.) Here, appellants have effectively alleged nothing more than a breach of contract claim which, as we have already discussed, must fail as no basis for recovery of damages has been pled. Indeed, in the context of the facts alleged in this case, the breach of contract and declaratory relief claims are identical. The declaratory relief claim would not prove to be any faster, more adequate, or better. Thus, appellants' cause of action for declaratory relief doesn't fall under the exception in *Warren* and states no viable claim for relief.

DISPOSITION

The judgment entered in favor of Hospital after the trial court sustained its demurrer without leave to amend is affirmed. Hospital shall recover its costs on appeal.

CROSKEY, J.

WE CONCUR:

KLEIN, P. J.

KITCHING, J.